Maricopa County
Prescription Drug Benefit Plan

Administered Through
Walgreens Health Initiatives (WHI)

Effective January 1, 2003

TABLE OF CONTENTS

SUMMARY PLAN DOCUMENT

MARICOPA COUNTY PRESCRIPTION DRUG BENEFIT PLAN

ADMINISTRATIVE INFORMATION

Plan Name:	Maricopa County Prescription Drug Benefit Plan
Plan Sponsor:	Maricopa County
Group Number:	512229
Type of Plan:	Prescription Drug Benefit Plan
Plan Administrator:	Walgreens Health Initiatives (WHI)
(Pharmacy Benefit Manager)	2275 Half Day Road, Suite 250 Bannockburn, IL 60015
Funding Mechanism:	Self-Insured
Plan Year:	January 1 to December 31

ABOUT THIS DOCUMENT

- This Summary Plan Document (SPD) is intended to describe your prescription drug benefit plan. Every effort has been made to ensure the information contained in this SPD is accurate. If there is a discrepancy in the information, the Plan Sponsor will make the final determination.
- The Plan Sponsor reserves the right to amend or terminate any benefit described in this document at any time. Notices of changes will be communicated through the Electronic Business Center (EBC), Maricopa County's Intranet.
- The Plan and/or WHI has the right to deny benefits for any drug prescribed or dispensed in a manner that does not conform to normal medical or pharmaceutical practices or that are received in a manner that does not conform to the plan design.
- When the words "we," "us," "our," and "Plan" are used in this document, they refer to Maricopa County. When the words "you" and "your" are used, they refer to the Maricopa County employees, retirees and COBRA participants who are covered for medical care through certain CIGNA medical products (CIGNA HMO, POS, and PPO).
- The Maricopa County Employee Benefits Office has two web sites for employee use. The address of the Internet site is http://www.maricopa.gov/benefits, and the EBC/Intranet site is located at http://ebc.maricopa.gov/hr/benefits. Both of these web sites are collectively referred to as the "Benefits Home Page" in this document.

INTRODUCTION

This summary plan document explains your prescription drug benefits, how you are able to access these benefits, and limitations and exclusions that apply. This document and the prescription drug benefit plan are effective January 1, 2003.

The prescription benefit plan is a three-tiered benefit. Tier One covers generic medications, Tier Two covers brand-name medications that are on the formulary (an approved list of generic and brand-name preferred drugs). Tier Three covers brand-name medications that are not on the formulary. Each Tier has minimum and maximum amounts that you will pay for a medication on that Tier. Each Tier also has coinsurance – a percentage of the cost of the medication. You will be charged the minimum, the maximum or the coinsurance amount for the medication based on the Tier the medication is on and the cost of the medication.

As mentioned above, the prescription benefit plan uses a formulary , created and maintained by WHI, the Plan Administrator. The formulary is a tool that guides you and your physician, when selecting medications, toward drugs that maximize your benefit.

The drugs on the formulary and drugs newly approved by the Federal Drug Administration (FDA) are reviewed periodically by WHI's Pharmacy and Therapeutics Committee. The Committee is comprised of physicians and pharmacists who are tasked with objectively evaluating drugs for therapeutic treatment, safety, and cost effectiveness in order to determine placement on the formulary.

The WHI Formulary Guide is mailed to newly enrolled participants shortly after enrollment along with an ID card and a registration form for mail order service. The Guide is also available via the Internet at WHI's web site, www.whphi.com. Please note that the Formulary Guide is a listing of the drugs on the formulary that are most commonly prescribed. Other drugs, especially generics, may be covered. Conversely, since the WHI formulary is used for many of WHI's other clients, **not all drugs listed in the Formulary Guide are covered under your prescription drug plan. Your prescription drug benefit plan has certain exclusions and limits that apply.** Please refer to the *EXCLUSIONS AND LIMITATIONS* section of this document for more information.

The brand name of a drug is the product name under which it is advertised and sold. By law, generic drugs must have the same U.S. Food and Drug Administration (FDA) standards for quality, strength and purity) as their brand name counterparts. Since the coinsurance for generic drugs is lower, ask your physician about prescribing generic drugs. The pharmacist may ask your physician whether a generic drug might be appropriate, however, your physician makes the final decision.

If you are an active employee, retiree, or have elected COBRA and are enrolled in a CIGNA HMO, POS, or PPO medical product, this prescription drug benefit plan benefit applies to you.

If your medical coverage is through CIGNA Healthcare for Seniors Group Medicare + Choice plan, or Maricopa Integrated Health System's (MIHS) HealthSelect or Maricopa Senior Select Plan (MSSP), an Individual Medicare + Choice plan, your prescription drug benefit is available through either CIGNA or MIHS. Please refer to your medical ID card to determine the type of medical plan under which you are covered.

UNDERSTANDING WHAT IS COVERED

To understand your prescription drug benefit, we ask that you read two sections immediately. These sections are entitled *DESCRIPTION OF PRESCRIPTION DRUG BENEFITS* and *SCHEDULE OF PRESCRIPTION COINSURANCE*.

The *DESCRIPTION OF PRESCRIPTION DRUG BENEFITS* section identifies the prescription benefits that are covered, and the *SCHEDULE OF PRESCRIPTION COINSURANCE* identifies your out-of-pocket expenses that are required to be paid at the time of service.

UNDERSTANDING WHAT IS NOT COVERED

To understand what is not covered under your prescription drug benefit, we ask that you read the section entitled *EXCLUSIONS AND LIMITATIONS* for a listing of what is not covered under the prescription plan. For specific drug categories that are not covered, refer to the *DESCRIPTION OF PRESCRIPTION DRUG BENEFITS* section.

YOUR FINANCIAL RESPONSIBILITY

Your prescription drug benefit charges you a percentage of the discounted average wholesale price (AWP) of the drug. This percentage charge is referred to as coinsurance. Coinsurance is your responsibility and must be paid directly to the pharmacy at the time your prescription is filled. Coinsurance amounts are listed in the *SCHEDULE OF PRESCRIPTION COINSURANCE* section. Minimums and maximum amounts may apply to your charges.

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS

OBTAINING COVERED PRESCRIPTIONS

You can obtain your prescriptions from three different sources, depending on your needs. The three sources are a retail pharmacy within the WHI national network, a Walgreens retail pharmacy, and mail order through Walgreens Healthcare Plus. All three sources have contracted pharmacies within the WHI network. Prescriptions filled at non-contracted pharmacies are not covered under your prescription drug benefit plan. An exception to obtaining prescriptions at non-contracted pharmacies exists if you are obtaining diabetic medications or supplies. Medications and supplies specific to the treatment of diabetes may be obtained through a CIGNA Medical Group facility pharmacy.

Medication may be obtained for up to a 30-day supply, or for a three-month supply. **Medication obtained in a quantity for a 31-83 day supply will not be covered under your benefit.**

For specific information about the cost of medication, see the *SCHEDULE OF PRESCRIPTION COINSURANCE* section.

Federal law prohibits the return of dispensed prescription medication.

SHORT-TERM NEEDS

UP TO A 30-DAY SUPPLY AT RETAIL PHARMACIES

WHI's retail network of pharmacies is available for prescriptions you need right away, for a short time only (such as antibiotics) or a monthly supply. You can choose from thousands of participating network pharmacies nationwide, and you can obtain up to a 30-day supply at one time. You can find the nearest participating network pharmacy by calling **WHI's Member Services** at **800-207-2568**, or by going on-line via the Internet to www.whphi.com. A small number of medications are limited to a 30-day or less supply, such as but not limited to, Accutane or Peg-Intron.

LONG-TERM NEEDS

THREE MONTH SUPPLY AT WALGREENS RETAIL STORES (PHARMACIES)

When you need prescriptions for chronic or long-term health conditions (such as high blood pressure, diabetes, or asthma) you can purchase a three-month supply at any pharmacy located in a **Walgreens Retail Store**. The physician must write your prescription for an 84–90 day supply.

THREE MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY

Prescriptions for maintenance medications or long-term health conditions can also be ordered through the Walgreens Healthcare Plus mail service pharmacy. Ordering through the mail is both a safe and convenient way to receive prescriptions and save money. You must use a specific order form when placing your first order. This form provides Walgreens Healthcare Plus with important health, allergy, and plan identification information. This form is called **Tempe Registration and Order Form** and is available online at the Benefits Home Page or at WHI's web site: www.whphi.com. You can even register online at the WHI web site instead of completing a hardcopy of the form. **Forms are not available through Walgreens Customer Service.**

Send the completed form, along with your original written prescription to **Walgreens Healthcare Plus, P.O. Box 29061, Phoenix, AZ 85038**. Be sure to include your group number, **512229**, on the form. You may pay by Check, money order, VISA, MasterCard, Discover, and American Express. Please do not send your debit card number or cash.

Your doctor can not phone in new prescriptions. However, your doctor may send a new prescription via facsimile (fax). The required form is called the **Tempe Physician Fax Order Form** and is available at www.whphi.com or by selecting the Member Forms link or the WHI link on the Benefits Home Page.

When your order is filled, it will be promptly delivered by U.S. Mail. Your package usually arrives within 7-10 days. Your order will include medication container(s), instructions for refills, and information about your medication.

To ensure you do not run out of your prescription, remember to reorder on or after the refill date indicated on your refill slip or medication container, or reorder when you have 14 days of medication left.

DRUG UTILIZATION ALERTS AT TIME OF PURCHASE

Drug Utilization Review (DUR) is an effective tool used by WHI in monitoring your drug use to assure that it is appropriate, safe, and effective. At the time of purchase, WHI's DUR program monitors your claim submissions across all pharmacies and prescribing physicians, compares each claim with your active prescriptions, and sends a notice to the pharmacists, if any drug utilization alerts occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) DUR guidelines, and monitors every prescription for numerous conditions. Examples of some of the DUR alerts are listed below.

DRUG/DRUG INTERACTION

A drug/drug interaction is a potentially harmful result that can occur when a patient is taking two or more drugs at the same time. The possible results of the interaction may include the increase or decrease in drug effectiveness or an increase in the adverse effects of one or both of the drugs.

When these interactions occur, the WHI system advises the dispensing pharmacist that the drug he/she is about to dispense may have a potentially harmful interaction with a drug the patient is currently taking. This allows the pharmacist to use professional judgement to intervene, if necessary, to prevent the patient from being harmed.

OVERUTILIZATION

The submission of prescription drug claims across all contracted pharmacies are monitored. When a prescription claim request is received, the WHI system reviews each patient's drug profile, searching for a previous prescription for the same drug or its generic equivalent. The system then applies any other parameters that have been defined to reject a claim, if the request for the medication is being submitted sooner than the plan recognizes as appropriate.

THERAPEUTIC DUPLICATION MONITORING

Duplicate therapy monitoring informs the dispensing pharmacist that the newly prescribed drug may duplicate the therapeutic effects of another drug already prescribed for the patient. This duplication can occur even when the two drugs are prescribed for different medical conditions.

When a duplication of therapy is detected, WHI will transmit information back to the dispensing pharmacist, including the name of the drug that is duplicating the therapy, for further evaluation and intervention.

RETROSPECTIVE DRUG UTILIZATION REVIEW

Walgreens Health Initiatives (WHI) reviews all prescriptions after they are purchased to assist your health care providers in their efforts to ensure safe and appropriate use of medications for you. As part of this program, WHI pharmacists may confidentially analyze your medication history in order to determine appropriateness of therapy. The prescribing doctor may be provided with the most recent educational materials based on nationally accepted therapy guidelines to assist in this determination.

SCHEDULE OF PRESCRIPTION COINSURANCE

QUANTITY	GENERIC – TIER 1 On Formulary	BRAND ON - TIER 2 (Preferred) On Formulary	BRAND OFF - TIER 3 (Non-Preferred) NOT On Formulary
Up to a 30-Day Supply at any Retail Pharmacies in the WHI Network	25% of contract rate minimum $2.00 maximum $10.00	30% of contract rate minimum $5.00 maximum $25.00	30% of contract rate minimum $20.00 maximum $50.00
Three Month Supply (84-90 day supply) at any Walgreens Retail Stores (Pharmacies)	25% of contract rate minimum $6.00 maximum $30.00	30% of contract rate minimum $15.00 maximum $75.00	30% of contract rate minimum $60.00 maximum $150.00
Three Month Supply (84-90 day supply) through the Walgreens Healthcare Plus Mail Service Pharmacy	20% of contract rate minimum $6.00 maximum $28.00	25% of contract rate minimum $15.00 maximum $70.00	25% of contract rate minimum $60.00 maximum $140.00

Note: Diabetic supplies and medications may be obtained at a CIGNA Medical Group facility for $10 per item.

MAXIMUM OUT-OF-POCKET LIMIT

The coinsurance, including minimum and maximum amounts, paid towards any covered drug will be applied to your maximum out-of-pocket limit. The maximum out-of-pocket limit is the most that you will pay for covered prescription drugs during a calendar year.

- The maximum out-of-pocket limit for individual coverage is $1,500.
- The maximum out-of-pocket limit for family coverage is $3,000.

Once you and/or your covered dependents meet their out-of-pocket maximum, covered prescriptions are paid 100% by the plan for the remainder of the calendar year. Any number of family members can contribute to the family out of pocket maximum. The amount you pay for any *non-covered drug* will not be included in calculating your annual out-of-pocket maximum. You are responsible for paying 100% of the cost for any non-covered drug.

Note: Diabetic supplies and medications obtained at a CIGNA Medical Group facility are not included in your maximum out-of-pocket limit.

COVERED ITEMS

The following items are covered under the prescription program, unless specifically listed in the *EXCLUSIONS AND LIMITATIONS* section.

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic medications and supplies such as blood glucose monitors, test strips, disposable insulin syringes, lancets (including automatic lancing devices), glucagon, prescribed oral agents for controlling blood sugar, and any of the devices listed above that are needed due to being visually impaired or legally blind.

  Note: Insulin pumps and cartridges are available through your CIGNA durable medical equipment (DME) provider.

EXCLUSIONS AND LIMITATIONS

- Drugs used for cosmetic purposes, including but not limited to, certain anti-fungals, hair loss treatments and those used for pigmenting/depigmenting and reducing wrinkles
- Fertility drugs (oral and injectible)
- Diabetic urine tests, alcohol swabs
- Nutritional/Dietary Supplements

  Note: Medical food products (low protein foods and metabolic formula) to treat inherited metabolic disorders (a disease caused by an inherited abnormality of body chemistry) are covered under your CIGNA medical plan according to Arizona state statute.
- Over-the-counter medications and other over-the-counter items
- Certain injectibles obtainable through a physician in an office setting. If the medication is available and administered through your physician's office, then it may be covered through your CIGNA in-network medical plan.
- Miscellaneous medical supplies
- Coverage for prescription drug products for an amount that exceeds the supply limit (either days supply or quantity limit).
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of employment for which benefits are available under any workers' compensation law or other similar laws.
- Charges to administer or inject any drug.
- Certain self-injectible drugs.
- Prescription drugs that are not medically necessary.
- Charges for delivering any drugs.
- Experimental or investigational medications
- Prescription drugs purchased from an institutional pharmacy for use while you are an in-patient in that institution (hospital, skilled nursing facility, or alternate facility), regardless of the level-of-care.
- Prescription drugs furnished by the local, state, or federal government.
- A specialty medication prescription drug product (such as immunizations and allergy serum) which, due to its characteristics as determined by the Plan Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
- Replacement prescription drug products resulting from a lost, stolen, broken or destroyed prescription order or refill.
- Prescription drug products for smoking cessation, unless they are provided through an approved Wellness Program through Maricopa County.

Note: Reimbursement for prescription drugs you purchased for full retail cost is subject to review under the Direct Member Reimbursement Process. Reimbursement may be limited to contract rate less coinsurance. Refer to the *DIRECT MEMBER REIMBURSEMENT* section.

FORMULARY MANAGEMENT

A formulary is a list of medications that have received FDA approval as safe and effective, and have been chosen for inclusion on the formulary by a committee of physicians and pharmacists. The formulary drug list can help you and your physician maximize your prescription benefits while minimizing overall prescription drug costs to you *and* the Plan Sponsor.

WHI's Pharmacy and Therapeutics (P&T) committee evaluates clinical efficacy and safety of each drug and votes the drug into one of three categories:

- **Therapeutically Unique** – Clinical effectiveness of the drug is superior to existing drugs with an acceptable safety profile, prompting automatic addition to the formulary
- **Therapeutically Equivalent** – Clinical effectiveness and safety profile are comparable to existing drugs
- **Therapeutically Inferior** – Clinical effectiveness of the drug is no greater than existing drugs and the safety profile is less favorable, prompting automatic non-formulary status

Products classified by the P&T committee as therapeutically equivalent are then further evaluated from an economic perspective to determine which clinically appropriate drugs are most cost-effective for clients. The P&T committee's evaluation is based solely on clinical criteria. It is only after the P&T committee's clinical assessment is made that the economics of the drug are considered.

New FDA approved drugs that arrive on the market are automatically available to you and are initially placed into the third tier (brand-off), except those excluded under your benefit plan. Based on the P&T committee's decision, the new drug may then be placed on the second tier (brand-on). Additions to the formulary may be made on a quarterly basis throughout the year with deletions most often occurring annually.

Three-Tier Coinsurance Level	Type of Medication
Lowest Coinsurance – Generic Tier 1	Medications classified as generic by First Data Bank.
Middle Coinsurance – Brand-On Tier 2	Preferred Brand medications on the formulary list with no generic available.
Highest Coinsurance – Brand-Off Tier 3	Non-preferred brands (not on formulary list) or brands with a generic available as classified by First Data Bank.

The most up-to-date Formulary Guide is available on the WHI web site at www.whphi.com.

Note: Drugs that are listed on the WHI Formulary may not be covered as they are subject to Maricopa County's specific plan coverages, exclusions, and limitations.

PRIOR AUTHORIZATIONS

Certain prescriptions require prior authorization (approval from the Plan before they will be covered). Types of prior authorizations, include, but are not limited to, medications where a set amount is allowed within a set timeframe and an additional amount is requested within the same timeframe, an age limitation has been reached and/or exceeded or appropriate utilization must be determined. WHI, in their capacity as pharmacy benefit manager, administers the clinical prior authorization process on behalf of Maricopa County.

Clinical Prior Authorization (CPA) can be initiated by the pharmacy, the physician, you, or your covered dependents by calling 1-887-665-6609, Monday through Friday, 8:00 a.m.-8:00 p.m., Central Standard Time. The pharmacy *may* call after being prompted by a medication denial stating "*Prior Authorization required, call 1-877-665-6609."* The pharmacy may also pass the information on to you and require you to request the prior authorization.

After the initial call is placed, the Clinical Services Representative obtains information and verifies that Maricopa County participates in a CPA program for the particular drug category. The Clinical Services Representative generates a drug specific form and faxes it to the prescribing physician. Once the fax form is received back into the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 48 hours from WHI's receipt of the completed form from the prescribing physician, not including weekends and holidays.

If the prior authorization request is approved, the WHI Clinical Service Representative calls the person who initiated the request and enters an override into the WHI processing system for a limited period of time. The pharmacy will then process your prescription.

If the prior authorization request is denied, the WHI Clinical Call Center pharmacist calls the person who initiated the request and sends a denial letter explaining the denial reason. The letter will include instructions for appealing the denial. For more information see the *APPEAL PROCEDURES* section.

Drug categories or medications that require prior authorization include, but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy
- Anabolic steroids (all forms)
- Insomnia
- Proton Pump Inhibitors (PPIs such as Prilosec, Prevacid, Nexium, Protonix and Aciphex),
- Cox II inhibitors (i.e., Celebrex, Vioxx and Bextra)
- Anti-obesity
- Anti-Fungals (i.e., Lamisil, Sporanox, and Diflucan)
- Migraine Medications (all forms of treatment)
- Stadol
- Singulair

The criteria for the Clinical Prior Authorization program are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice. Each specific guideline has been reviewed and approved by WHI's Pharmacy and Therapeutics (P&T) Committee for appropriateness.

To confirm whether you need prior authorization and/or to request a prior authorization, call **WHI's Clinical Member Services at 877-665-6609**, Monday through Friday, 8:00 a.m.-8:00 p.m., Central Standard Time. Please have the information listed below available when initiating your request for prior authorization:

- Name of your Medication
- Prescribing Physician's Name
- Prescribing Physician's Phone Number
- Prescribing Physician's Fax Number, if available
- WHI member ID number (from your WHI ID card)
- Maricopa County Group Number: **512229**

AGE AND QUANTITY LIMITATIONS

Some medications are subject to age and quantity limits. Your claim will be denied at the time of purchase if it exceeds these limitations. Limitations are based on criteria developed with guidelines from various national medical agencies, in conjunction with WHI's clinical review process.

AGE LIMITATIONS

Certain medications have an ***age*** limitation, including but not limited to the following health conditions:

- Topical Acne
- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy

If your prescription is denied due to age limitations, but you and your physician believe that it is medically necessary for you to take this medication to treat one of the above conditions, you may request Prior Authorization. Refer to the *PRIOR AUTHORIZATIONS* section for details.

QUANTITY LIMITATIONS

Certain medications have ***quantity*** limitations, including but not limited to the following health conditions and medications:

- Impotency*
- Insomnia
- Migraine Medications
- Stadol
- Diflucan
- Proton Pump Inhibitors (PPIs)

*__Note__: Impotency limitation is a set monthly quantity. Prior Authorization does not apply to this class of medication.

If your prescription is denied due to quantity limitations and you and your physician believe that it is medically necessary for you to take a larger quantity of this medication, you may request Prior Authorization. Refer to the *PRIOR AUTHORIZATIONS* section for details.

SPECIALTY PHARMACY PROGRAM

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Health Initiatives Specialty Pharmacy Program.

The purpose of the Specialty Pharmacy Program is to assist you with monitoring your medication needs for conditions such as those listed below and providing patient education. The Program includes monitoring of specific injectible drugs and other therapies requiring complex administration methods, special storage, handling, and delivery.

Medications covered through the Specialty Pharmacy Program include, but are not limited to, the following conditions:

- Cystic Fibrosis
- Multiple Sclerosis
- Viral Hepatitis
- Growth Hormone Deficiency

Medications through the Specialty Pharmacy Program may only be obtained through a retail Walgreens store in 30-day increments or through Walgreens Healthcare Plus home delivery service.

Note: Walgreens Healthcare Plus home delivery service is similar to Walgreens Healthcare Plus mail service pharmacy. The difference is that Walgreens Healthcare Plus home delivery service allows for 30-day increments in the Specialty Pharmacy Program.

You may enroll in the Specialty Pharmacy Program by contacting **WHI's Specialty Care Pharmacy Center** at **1-888-782-8443**, or a Specialty Care Representative may contact you to facilitate your ongoing prescription needs. Trained Specialty Care pharmacy staff is available 24 hours a day, 7 days a week to assist you.

ELIGIBILITY REQUIREMENTS

If you are an active employee, retiree, or have elected COBRA and are enrolled in a CIGNA HMO, POS, or PPO medical product, this prescription drug benefit plan benefit applies to you.

If your medical coverage is through CIGNA Healthcare for Seniors Group Medicare + Choice plan, or Maricopa Integrated Health System's (MIHS) HealthSelect or Maricopa Senior Select Plan (MSSP), an Individual Medicare + Choice plan, your prescription drug benefit is available through either CIGNA or MIHS. Please refer to your medical ID card to determine the type of medical plan under which you are covered.

TERMINATION

Coverage ends the last day of the payroll period in which you cease to be eligible for coverage and for which premium was paid or the last day of the payroll period in which you cease to be in a benefit-eligible position, whichever comes first. Please refer to *WHO'S ELIGIBLE?* and *DO BENEFITS CONTINUE WHILE ON A LEAVE OF ABSENCE?* sections of the *Know Your Benefits* guide for details.

EXCEPTIONS

- Dependent spouse and stepchildren coverage ends on the date of divorce.
- Dependent child coverage ends the date the child loses dependent status either due to reaching an age limitation, ending attendance in an institution of higher education, marriage, changing to a different residence than yours, ending of a support order, or changing in support requirements (i.e., no longer primarily dependent upon you for more than 50 percent of his/her support).

You are responsible for immediately notifying the Benefits Office when a dependent no longer meets the eligibility requirements listed in the *ARE DEPENDENTS COVERED?* section of the *Know Your Benefits* guide. Prescription and administrative costs paid or incurred on behalf of an ineligible dependent become your liability.

When any of the following happen, we will provide you written notice that coverage has ended on the date we identify in the notice.

- **Fraud, Misrepresentation, or False Material Information**: You provided false information relating to another person's eligibility or status as a dependent.
- **Improper Use of ID Card**: You permitted an uncovered person to use your ID card.
- **Failure to Pay**: You failed to pay the required premium for coverage.
- **Threatening Behavior**: You commit an act of physical or verbal abuse that poses a threat to staff of the Benefits Office or a provider, including a pharmacist.

RIGHT OF RECOVERY

If the amount of payment we made is more than we should have paid, we may recover the excess from you or from one or more of the persons we paid. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

IDENTIFICATION CARDS

Walgreens Health Initiatives (WHI) issues identification cards to you for identification purposes only. The identification card is not proof of coverage or eligibility for services on a particular date of service.

You should either show your ID card at the time you obtain your prescription drug product at a contracted (participating) pharmacy or you must provide the pharmacy with identifying information that can be verified with the Benefits Office during regular business hours.

The computer system at the pharmacy will confirm your eligibility for benefits even if you do not have your WHI ID card with you, as long as you provide the pharmacist with the following information:

- RxBIN 603286
- RxPCN 01410000
- RxGro 512229
- Issuer (80840)
- Your name
- Your WHI ID number (either your Social Security Number or your alternative ID number)

If you don't show your ID card or provide verifiable information, you will be required to pay for the prescription drug product at the pharmacy. Our contracted pharmacy reimbursement rates (our prescription drug cost) will not be available to you.

You may receive reimbursement from us as described in the *DIRECT MEMBER REIMBURSEMENT* section. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the prescription drug product was dispensed. The amount you are reimbursed will be based on the predominant reimbursement rate, less the required coinsurance.

To be entitled to the covered prescription medication, you must be the employee, or a covered dependent on whose behalf all applicable premiums have been paid. Any person receiving a covered prescription medication, who is not entitled, including, but not limited to fraudulent information submitted to WHI, will be fully responsible for reimbursement of the covered prescription medication.

If you lose your ID card or need additional cards for covered dependents, call **WHI Member Services** at **800-207-2568** and provide your name and your ID number. Your ID number is either your Social Security Number or an alternative identification number. Two additional cards will be sent to your address on file with Maricopa County's Human Resources Employee Records Office. Please note that only the employee's name is listed on the ID card. However, your eligible and enrolled dependents may access their prescription drug benefit by using your ID card.

DIRECT MEMBER REIMBURSEMENT

There may be instances where you are in need of a prescription for which you are eligible but are unable to have your claim processed through a WHI pharmacy due to situations such as being outside of the service area, an emergency situation, or a new member whose enrollment has not been processed. In situations such as these, you will be required to pay the full retail cost of the covered medication.

You can receive reimbursement for covered prescriptions you've paid for under the Plan by following these steps:

1. Pay the pharmacist the full amount of your prescription. Keep your receipt(s).
2. Obtain and complete a Direct Member Reimbursement (DMR) claim form available from the Benefits Home Page.
3. Send your completed form and itemized receipts to the Benefits Office address 301 West Jefferson, Suite 201, Phoenix, AZ 85003. DMR requests must be received at the Benefits Office within six months from the date of service to be eligible for reimbursement.

The Benefits Office will make a determination and if approved will forward your claims to WHI to process your request for reimbursement according to the Plan's guidelines, coverages, and limitations. If the request is approved, you should receive your reimbursement within four weeks.

Please note that WHI will reimburse you according to the Plan's guidelines. In most cases you will receive the contracted amount of the medication less your coinsurance instead of the full retail price of the medication, unless there was an administrative error on the part of the Benefits Office.

APPEAL PROCEDURES

If you are dissatisfied with the service received under this prescription drug benefit, you are encouraged to contact **Walgreens Health Initiatives (WHI) Member Services Department, 24 hours per day, 7 days a week at 1-800-207-2568**. Frequently, your concern can be resolved with a telephone call to a Member Service Representative. If the WHI Member Service's Department cannot resolve your concern, you may proceed to the Maricopa County Appeal Procedures as set forth below. Examples of concerns for which you may file an appeal include, but are not limited to, quality of service received, the design of the prescription drug benefit plan, denial of a clinical prior authorization of a drug, payment amount, or denial of a claim issue. Please note that denials of a clinical prior authorization due to medical information not being received by WHI from your physician will not be considered for the appeal process.

MARICOPA COUNTY'S APPEAL PROCEDURE

You may file an appeal in writing by completing the **Pharmacy Program Appeal Form** that is available on the Benefits Home Page. You may submit this form in person or by mail to a Benefits Representative located in the Maricopa County Employee Benefits Office at 301 W. Jefferson St., Suite 201, Phoenix, AZ 85003, Monday through Friday, 8:00 a.m.–5:00 p.m. You will be notified of receipt of the appeal in writing within five business days.

If the appeal is non-medical in nature, you will receive a response from the Maricopa County Benefits Office. Turnaround time for non-medical concerns is 30 calendar days from the date the Benefits Office receives the appeal. If additional research is required to resolve your appeal, you will receive a written progress report prior to the thirtieth day and at 30-day intervals until a determination is rendered.

If the appeal is regarding a denial of a clinical prior authorization or other clinical issue, an independent review organization (IRO) contracted by Walgreens Health Initiatives (WHI) will provide you with the resolution.

For denied clinical prior authorization appeals, the Plan Sponsor will track and forward the appeal form to WHI's Clinical Call Center. WHI will forward the appeal request to the IRO for review. The IRO assigns an independent physician to review your issue based on the case. The IRO physician will review the appeal and make a recommendation. The IRO submits their recommendation to WHI's Clinical Call Center, who notifies you, by mail, of the resolution with a copy to the Plan Sponsor. The turnaround time for a clinical prior authorization appeal is five business days from the date the appeal is received by the IRO, excluding holidays and weekends.

If the appeal is regarding a clinical issue such as prospective reviews, quality of care, retrospective reviews, or other types of appeal requests that are not classified as a clinical prior authorization, the appeal follows the same process as above with a turnaround time of five to 15 business days from the date the IRO received your information, excluding holidays and weekends.

NETWORK

You can choose from more than 50,000 contracted (participating) pharmacies. Below are some of the many pharmacies participating in the WHI nationwide retail network. For additional participating pharmacies call **WHI's Member Services at 800-207-2568**, 24 hours a day, 7 days a week or visit the WHI web site at www.whphi.com.

- Albertsons Pharmacy
- Brooks Pharmacy
- Costco Pharmacy
- Eckerd Drug
- Fred Meyer
- Freds
- Fry's Pharmacy
- Genovese
- Hy Vee Pharmacy
- Kerr Drug
- Kmart
- Kroger Pharmacy
- Longs Drug Stores
- Medicap Pharmacy
- Meijer
- Osco
- Pathmark
- Payless
- Publix Pharmacy
- Randalls
- Rite Aid
- Safeway Pharmacy
- Sam's Club
- Sav-on Drugs
- Shop Rite Pharmacy
- Shopko
- Smith's Food & Drug
- Super D Drugs
- Target
- Thrifty Drug
- United
- Walgreens
- Wal-Mart

IMPORTANT PHONE NUMBERS

NAME	PHONE	HOURS	WHO	REASONS TO CALL *(including but not limited to)*
WHI Member Services	800-207-2568 Toll free	24 hours a day, 7 days a week	• Members • Dependents • Pharmacies • Maricopa County benefits personnel	• Eligibility • Prescription will not process • Find out if a drug is covered • Find out if drug is on formulary • Find out your coinsurance
WHI Clinical Call Center	877-665-6609 Toll free	Monday – Friday: 8:00 a.m.–8:00 p.m. (Central Standard Time)	• Members • Dependents • Pharmacies • Physicians • Maricopa County benefits personnel	• Initiate a clinical prior authorization (CPA) review • Check status of a CPA review • Check to see if prior authorization is required for a drug *(See PRIOR AUTHORIZATION section for details.)*
WHI Specialty Pharmacy Center	888-782-8443 Toll free	Monday – Friday: 8:00 a.m.–10:00 p.m. (Eastern Standard Time)	• Members • Dependents • Physicians	• Obtain a specialty medication • Check on status of a specialty drug (See *SPECIALTY PHARMACY* section for details.)
Walgreens Healthcare Plus Mail Service Pharmacy	888-265-1953 Toll free	Monday – Friday: 7:00 a.m.–7:00 p.m. Saturday: 7:00 a.m.–Noon (Mountain Standard Time)	• Members • Dependents	• Check on status of a mail order prescription
Maricopa County Employee Benefits Office	602-506-1010	Monday – Friday: 8:00 a.m.–5:00 p.m. (Mountain Standard Time)	• Maricopa County employees	• Eligibility • File an appeal (See *APPEAL PROCEDURE* section for details.) • Reimbursement for prescriptions for which you paid (See *DIRECT MEMBER REIMBURSEMENT* section for details.)